County of Los Angeles
CHIEF EXECUTIVE OFFICE
Kenneth Hahn Hall of Administration
500 West Temple Street, Room 713, Los Angeles, California 90012
(213) 974-1101
http://ceo.lacounty.gov

SACHI A. HAMAI
Interim Chief Executive Officer

September 29, 2015

To: Supervisor Michael D. Antonovich, Mayor
Supervisor Hilda L. Solis
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Don Knabe

From: Sachi A. Hamai
Interim Chief Executive Officer

REPORT BACK ON NEED TO ESTABLISH A COUNTY OFFICER INVOLVED SHOOTING/DEATH IN CUSTODY REVIEW TEAM (ITEM NO. 14, AGENDA OF JUNE 22, 2015)

On June 22, 2015, the Board directed the Chief Executive Office (CEO) to report back during Supplemental Changes with more information regarding the use of law enforcement security holds and recommendations on Officer Involved Shooting (OIS)/Death in Custody (DIC) review teams.

Background

On June 12, 2015, the Department of Medical Examiner-Coroner (DMEC) distributed a memo to the Board responding to statements made by a representative from Long Beach in regards to the perceived lengthy time it takes for the DMEC to compile and release autopsy findings in OIS cases, as well as other DIC cases (Attachment I). In the letter, the DMEC indicates its issues with the use of security holds by law enforcement agencies, the perceived lack of transparency related to the use of security holds, and explores the implementation of an independent review process of OIS and DIC cases.

On June 16, 2015, the CEO reported that DMEC would be implementing an internal review process consisting of a team of existing DMEC physicians, criminalists, investigators and operational staff to review OIS and DIC cases to ensure efficiency, quality and uniformity. The CEO also reported that it would review and report on the various types of OIS/DIC review teams that are available for Los Angeles County (Attachment II).

Security Holds

To maintain the integrity of criminal investigations, law enforcement agencies routinely request the DMEC to place a security hold on DMEC autopsy reports. A security hold temporarily exempts, from public disclosure, completed DMEC autopsy reports that have assigned cause and manner of death determinations in cases coming within the jurisdiction of the Chief Medical Examiner-Coroner. The DMEC, as a matter of policy, complies with the law enforcement agency security hold requests. In certain instances, law enforcement agencies neglect to inform the DMEC that its investigation has concluded and that the DMEC autopsy report may be removed from its security hold. This has unnecessarily delayed the release of DMEC autopsy reports to the public.

Beginning on September 1, 2015, in an effort to balance the public investigative needs of law enforcement agencies with the right of access to public records, DMEC will require that law enforcement agencies submit written justifications for each security hold it has placed on DMEC autopsy reports every 90 days. It is the intent that this change in procedure will result in a more timely public release of DMEC autopsy reports, when law enforcement agencies have determined that such release will not compromise the safety of an individual, or interfere with an investigation.

Departmental Internal Review of OIS and DIC Cases

Commencing July 1, 2015, DMEC implemented an internal review process consisting of DMEC physicians, criminalists, investigators and operational staff to review and analyze preliminary cause and manner of death findings in OIS and DIC cases to support quality assurance efforts. The cases will be reviewed to ensure efficiency, quality and uniformity in investigatory procedures and medico-legal findings.

Expanded Departmental Internal Review

In its memo, DMEC indicated that other types of adjudication processes could be utilized to provide additional transparency in OIS and DIC cases. Prior to the implementation of any new review process which includes law enforcement agencies, such as the District Attorney or the Grand Jury, it is recommended that the Board examine the agencies that currently investigate OIS and DIC cases to determine if a new investigative effort is duplicative, overlapping, or necessary. Many OIS and DIC investigative agencies already incorporate DMEC autopsy report findings in their reviews.

Medical Examiner's Inquest

A Medical Examiner-Coroner's inquest process involves the use of a jury to determine a non-binding verdict on the manner and cause of death in a case. The inquest process has not been used in the County of Los Angeles since 1981 and is not recommended for reimplementation, as this process is unnecessary for the DMEC to make a cause and manner of death determination in OIS and DIC cases.

Should you or your staff have any questions, please contact Sheila Williams, Public Safety, at (213) 974-1155, or at swilliams@ceo.lacounty.gov.

SAH:JJ:SK
SW:MI:cc

Attachments

c: Executive Office, Board of Supervisors
County Counsel
District Attorney
Sheriff
Medical Examiner-Coroner
Grand Jury

PS.MEC - OIS DIC Review Team Update.bm.092915.docx

ATTACHMENT I

COUNTY OF LOS ANGELES

DEPARTMENT OF MEDICAL EXAMINER-CORONER

1104 N. MISSION RD. LOS ANGELES, CALIFORNIA 90033

"Enriching Lives"

Mark A. Fajardo, M.D.
Chief Medical Examiner-Coroner

June 12, 2015

TO: Mayor Michael D. Antonovich
Supervisor Hilda L. Solis
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Don Knabe
Sachi A. Hamai

FROM: Mark A. Fajardo
Chief Medical Examiner-Coroner

SUBJECT: OFFICER INVOLVED SHOOTING/DEATH IN CUSTODY REVIEW

This letter is written in response to a statement made by a Long Beach Councilwoman to Supervisor Knabe, in regards to the perceived lengthy time it takes for the Department of Medical Examiner-Coroner to compile and release autopsy findings in Officer Involved Shooting cases as well as other Death in Custody cases. My office prides itself on the ability to provide quality death investigation that is accurate, encompassing, thorough, useable and timely. We comply with the National Association of Medical Examiner's criteria that ninety per cent of our cases are completed in ninety days or less. As I reported to Supervisor Knabe, our Death in Custody/Officer Involved Shooting cases are our second highest priority cases (only second to babies) and we try to clear them as efficiently (but also as accurately) as possible. The perceived lengthy time on these (usually) very difficult cases is secondary to the necessity to analyze and collate all of the ancillary testing and reports (i.e. toxicology, neuropathology, medical records, police reports, Taser reports, etc.) to derive an accurate opinion as to Cause and Manner of Death.

Complicating this issue is the Security Hold process. As you are aware, by statute, law enforcement agencies, including the District Attorney's Office, can place a security hold on our cases which essentially prevents us from releasing information that would otherwise be released to the public. By statute, we cannot release this information without the express release by the agency that originally placed the hold. This process has garnered much media attention, especially in the Ezell Ford case, and in response, open dialogue with LAPD and the Sheriff's office was instituted to streamline the Security Hold process to ninety days, at which point information will be released, unless a positive request for extension of the security hold is made by the requesting law enforcement agency. These processes remain in the initial stages of implementation, but both LAPD and LASO are supportive of streamlining and becoming more efficient.

From an independent Medical Examiner-Coroner perspective, I was concerned with the public outcry for transparency after the Ezell Ford and Omar Abrego shootings, as well as other high profile Officer Involved Shooting cases that have occurred in the last few months. In response, in January of this year, I met with DA Jackie Lacey to explore the idea of implementing an independent review process, performed by my office, of Officer Involved Shootings and Deaths in Custody. As you can imagine, this review process can be something as simple as an internal review process, (that Sheriff Jim McDonnell likened to a Comp Stat process) to a more ambitious process with invitations to Law Enforcement/Grand Jury, to the extreme process of holding a Coroner's Inquest on the Officer Involved Shooting cases (which Clark County in Nevada and Contra Costa County in the Bay Area continue to perform regularly). In May of this year, I met with Sheriff Jim McDonnell, to discuss this particular topic (as well as others), and he was supportive of this independent review process. I have also discussed this topic with our County Counsel representative, to see which model would be best to institute.

Coming from a Sheriff-Coroner jurisdiction (Riverside County) I was fairly familiar and comfortable with the process that has become to be known as the "Coroner Review" process. Similar processes, which I have also participated in, are also in place in Orange County and San Bernardino counties, in which a formal review occurs in the presence of invited/involved law enforcement agencies, representatives from the District Attorney's Office and representatives from the standing Grand Jury. Although these Coroner Reviews are held to primarily proffer transparency and avoid conflicts of interest given the Sheriff-Coroner model, I believe they are extremely useful in a multitude of other ways as well.

After much deliberation, I thought it best to start off small, and expand in the future, if warranted. To this end, a formal Law Enforcement Involved/Death in Custody review team has been in the planning stages for the last nine months and will commence with the intake of cases starting July 1st of this year. It will be (initially) a strictly internal review process that will support our Risk Management efforts, and will be from a Quality Assurance perspective, to ensure efficiency, quality and uniformity when certifying these most difficult of cases. I believe that it will improve our throughput, as well as improve our working relationships with our law enforcement partners/customers. To what level of participation law enforcement, the District Attorney's Office, or the Grand Jury will have in the future, remains to be seen. I welcome any input or questions you may have. As always, thank you for your support.

MF:ic

C: Elaine Palaiologos
Craig Harvey

ATTACHMENT II

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SACHI A. HAMAI
Interim Chief Executive Officer

June 22, 2015

To: Mayor Michael D. Antonovich
Supervisor Hilda L. Solis
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Don Knabe

From: Sachi A. Hamai
Interim Chief Executive Officer

REPORT BACK ON FUNDING NEEDED TO ESTABLISH A COUNTY OFFICER INVOLVED SHOOTING/DEATH IN CUSTODY REVIEW TEAM (ITEM NO. 54-C, AGENDA OF JUNE 16, 2015)

On June 16, 2015, the Board directed the Chief Executive Office to report back at the Board's budget deliberations meeting on June 22, 2015 with more informative detail regarding the Officer Involved Shooting (OIS)/Death in Custody (DIC) review team, as well as, provide the Board with a recommendation that ensures this new review team will be funded at a level which makes these cases amongst the highest priorities.

On June 12, 2015, the Department of Medical Examiner-Coroner (DMEC) distributed the attached letter to the Board, responding to statements made by a representative from Long Beach. in regards to the perceived lengthy time it takes for the DMEC to compile and release autopsy findings in OIS cases, as well as, other DIC cases (Attachment I). In the letter, the DMEC indicates that in response to these claims, meetings with the District Attorney (DA) and Sheriff Department (Sheriff) were held to explore the idea of implementing an independent review process of these shootings and in-custody deaths. Several options were considered; however, ultimately the DMEC determined that a Department-only internal review process, utilizing existing staff, should be the starting point, and no staff or additional resources were requested as part of the Final Changes.

Therefore, commencing July 1, 2015, a team consisting of DMEC physicians, criminalists, investigators, and operational staff will meet to review and analyze these cases to support risk management and quality assurance efforts. The cases will be reviewed to ensure efficiency, quality, and uniformity.

Our office will continue to work with the DMEC, DA, and Sheriff to determine the type of OIS/DIC review team that is appropriate for Los Angeles County. Options for consideration by the Board are:

- Department Internal Review Process (similar to Law Enforcement Comp Stat)
- Department Internal Review Process which includes law enforcement, DA and the Grand Jury
- DMEC Inquest

Should you or your staff have any questions, please contact Sheila Williams, Public Safety, at (213) 974-1155.

SAH:JJ:SK
SW:MI:cc

Attachment

c: Executive Office, Board of Supervisors
County Counsel
District Attorney
Medical Examiner - Coroner

PS.MEC - OIS DIC Review Team.bm.062215.docx